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- (b) costs as determined by paragraphs (b) through (f) at the date of the subsequent transaction.
- h. For a facility having an addition, expansion, or renovation after June 14, 1983, reimbursement will be determined as follows:
 - (i) If the facility was being reimbursed under the provisions of paragraphs (a) through (g), reimbursement will not be increased as the result of renovation unless all of the following conditions are satisfied:
 - the renovation is mandated by state or federal law as implemented through policies and procedures of the Georgia Department of Human Resources Standards and Licensure Unit
 - the additional reimbursement is determined by a replacement cost appraisal (however, at the Division's discretion, for capital items not affecting the entire facility, multiple, competitive arm's length bids by contractors can be used instead of replacement cost appraisals).
 - the provider could not with reasonable diligence ascertain that the renovation would be required by the Georgia Department of Human Resources Standards and Licensure Unit. Reasonable diligence will include but is not limited to obtaining an inspection and its

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resulting report by the Architect of the Standards and Licensure Section specifically for the purpose of determining what repairs, renovations or other actions will be required of the facility to meet all applicable physical plant requirements, as well as all other inspections and deficiency reports on file at the Georgia Department of Human Resources Standards and Licensure Unit for that facility.

- (ii) If the facility was being reimbursed under the provisions of paragraphs (a) through (g), reimbursement for additions and expansions will be subject to limitations described in paragraphs (b) through (f). If the addition or expansion does not add beds, there will be no additional reimbursement. If beds are added, the addition will be treated in a manner similar to a new facility to determine a separate property rate sub-component for the addition.

1002.6 Overall Limitations on Total Allowed Per Diem Billing Rate

In no case shall the Total Allowed Per Diem Billing Rate, whether determined under either Section 1002.2 or Section 1002.3, Nursing Facility Manual, exceed the facility's customary charges to the general public for those services reimbursed by the Division.

1002.7 Payment in Full for Covered Services

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The facility must accept as payment in full for covered services the amount determined in accordance with Section 1002, Nursing Facility Manual.

1002.8 Adjustments to Rates

Payment rates for state-owned nursing facilities will be prospectively adjusted to 100% of service costs. This provision will apply in addition to all others in this chapter and will supersede those which are in direct conflict only to the extent that they are not capable of simultaneous application.

1003. Additional Care Services

1003.1 Required Nursing Hours

The minimum required number of nursing hours per patient day for all Level I and Level II nursing facilities is 2.50 actual working hours.

1003.2 Increase in Routine Services Percentile

The Routine Services percentile for all nursing facilities is the 90th percentile for the purpose of recognizing cost and the 90th percentile for calculating the incentive. Incentives calculated on July 1, October 1 or April 1 will not be adjusted except as a result of audits of a cost report or other allowable cost changes.

1003.3 Addition of Intensity Allowance

A four percent intensity allowance will be added to the current growth allowance rate for all cost centers except Property and Related for all Level I nursing facilities. A three (3) percent intensity allowance will be added to the current growth allowance rate for all cost centers except Property and Related for Level II nursing facilities, which maintain an average Medicaid skilled care occupancy level of 15 percent or greater

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during a six-month reporting period described in 1003.4 below. Level II nursing facilities which maintain an average Medicaid skilled care occupancy level of 25 percent or greater during a six-month reporting period as described in 1003.4 below will receive a four (4) percent intensity allowance. A (5) percent intensity allowance will be given to freestanding Level II facilities which maintain an average Medicaid skilled care occupancy level from 50% to 60% for a six-month reporting period. These allowances are to cover the cost of oxygen, catheters, parenteral supplies and other special supplies associated with heavy care patients.

The intensity allowance is a recognition of an increasingly severe patient case mix and the technological demands associated with the care therapies for that case mix. The January 1 to June 30 census information report described in 1003.4 below will be used to determine the appropriate intensity allowance for the period October 1 to March 31. The July 1 to December 31 census information report described in 1003.4 below will be used to determine the appropriate intensity allowance for the period April 1 to September 30.

1003.4 Medicaid Skilled Care Occupancy Report

All census information must be submitted using the Occupancy And Rate Data form, no later than January 31 and July 31 for the six-month periods ending December 31 and June 30, respectively, of each year. Medicaid recipients who also are recipients of Medicare and have payments made in their behalf by Medicare must be included in the appropriate Medicaid occupancy column on Schedule A.

1003.5 Failure to Comply

- a) The minimum standard for nursing hours is 2.50. All Level I and Level II facilities (including hospital-based) must comply with the 2.50 nursing hours standard.

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- b) Facilities found not in compliance with the 2.50 nursing hours will be cited for being out of compliance with a condition of participation. This will lead to imposition of a civil monetary penalty, denial of reimbursement for newly admitted patients, or suspension or termination whichever is appropriate as determined by the Division.
- c) Level II facilities (including hospital-based) which fail to maintain an average skilled patient occupancy level of 15 or 25 percent (as described in 1003.3) during a reporting period and freestanding Level II facilities which fail to maintain an average skilled patient occupancy level of from 50 to 60 percent for the reporting period will have the intensity allowance(s) reduced as appropriate for the applicable six-month period(s), beginning on October 1 or April 1, as indicated in 1003.3 above.
- d) Facilities submitting late or no reports (as required in Section 1003.4) may be assessed \$10 per day of lateness. A facility which submits a report more than 30 days after the deadline will have its rate reduced by the amount of its intensity allowance. Falsification of reports will result in reduction of payment, a minimum thirty-day denial of payment for newly admitted Medicaid residents, suspension or termination from the program or criminal prosecution, whichever is appropriate as determined by the Division.

1006. Freestanding Nursing Facility Classification and Reimbursement Based On Medicaid Skilled Care Occupancy

- 1006.1 a) If a Level I facility maintains an average Medicaid skilled care occupancy level of 85% or more for a reporting period, the facility's reimbursement rate will not be adjusted for level of care.

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- b) If a Level I facility's average Medicaid skilled care occupancy level is from 75% to 85% for a reporting period, the facility's rate for a skilled care patient will not change, but the rate for an intermediate care patient will include 95% of the facility's Routine Services and Dietary allowed per diems, plus 100% of the facility's allowed per diems for Laundry and Housekeeping and Administrative and General, plus property and the appropriate growth allowance.
- c) If a Level I facility's average Medicaid skilled care occupancy level is from 60% to 75% for a reporting period, the rate for a skilled care patient will not change, but the rate for an intermediate care patient will include 90% of the facility's Routine Services and Dietary allowed per diems, plus 100% of the facility's allowed per diems for Laundry and Housekeeping and Administrative and General, plus property and the appropriate growth allowance.
- d) If a Level I facility's average Medicaid skilled care occupancy level is less than 60% for a reporting period, the facility will be reclassified as a Level II nursing facility and the facility's rate will be calculated using the standard per diems appropriate for the Level II classification, plus property and the appropriate growth allowance.
- e) If a Level II facility maintains an average Medicaid skilled care occupancy level of 60% or more for a reporting period, the facility will be reclassified as a Level I nursing facility. The facility's rate using the current cost report and Level I standards.
- f) If a Level I facility's combined Routine Services and Dietary allowed per diems are less than the combined Level II Routine Services and Dietary

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standard per diems, there will not be an adjustment
as described in items (b) and (c) above.

1006.2 All new freestanding nursing facilities initially will be classified as Level II or ICF/MR, as appropriate. If a new facility meets the requirements for classification as Level I (as described in 1006.1), the facility must submit monthly Medicaid skilled care occupancy reports and any other documentation to the Division to justify reclassification. For reimbursement purposes, a new facility will be reclassified based on the first monthly occupancy report which documents that requirements for Level I classification have been met. The monthly occupancy reports must be received by the Division each month until the first January to June or July to December report is due as required by Subsection 1003.4. In order to remain in the Level I classification, the monthly or other period occupancy reports received must continue to justify Level I status; otherwise, reclassification to Level II will occur immediately. This information is subject to review by the Division or its agents.

1007. The maximum allowable payment for Medicare nursing facility coinsurance (crossover) claims will be the nursing facility's Medicaid specific per diem rate in effect for the dates of service of the crossover claims. The crossover claims will not be subsequently adjusted due to subsequent per diem rate adjustments. This section is also included in Chapter 1100 of the Manual.

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APPENDIX D

**UNIFORM CHART OF ACCOUNTS, COST REPORTING,
REIMBURSEMENT PRINCIPLES AND OTHER REPORTING
REQUIREMENTS**

General

This appendix discusses the use of a uniform chart of accounts, the annual submission of a cost report, the principles of reimbursement which comprise the basis for the financial reporting requirements of facilities participating in the Georgia Medicaid Program and other reporting requirements. The Georgia Division of Medical Assistance Uniform Chart of Accounts as comprised on the date of service is incorporated by reference herein. A copy is available from the Division upon request. Cost reports and instructions are made available to each facility near the end of the reporting period. The reimbursement principles discussed in this appendix are selected from the Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1). Copies of the Manual, which provide a detailed description of allowable costs, are available from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

1. Uniform Chart of Accounts

The Georgia Division of Medical Assistance requires that all nursing homes participating in the Medicaid Program utilize the classification of accounts shown in the Uniform Chart of Accounts in reporting its financial operations in the cost reporting system. While it is not mandatory that books of original entry or ledgers be maintained in accordance with the Uniform Chart of Accounts, facilities are strongly encouraged to do so. The Uniform Chart of Accounts has been designed to meet management needs for budgeting information, information flow, internal control, responsibility accounting and financial reporting. Also, it has been designed in such a manner that accounts may be added or deleted to tailor the financial information to the facility's needs.

Should a facility elect to maintain its books of original entry or ledgers in a manner other than that specified in the Uniform Chart of Accounts, the

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facility is required to have available a detailed description of how its accounting system differs. This description of differences must be used by the facility for converting the output of its reporting system into the format specified in the Uniform Chart of Accounts. This description of differences and conversion of reporting information into the proper format are considered to be essential components of a facility's accounting records. When such information is needed but not maintained, a facility's cost report will be determined to be unacceptable for fulfilling reporting requirements and penalties described in Section 2.b and 2.g of this appendix will be imposed.

2. Cost Reporting

Reimbursement of expenses incurred by nursing homes in the provision of care to Medicaid recipients is accomplished through the mechanism of the cost report. This document reports historical costs and details recipient occupancy data experienced during the fiscal year. The following cost reporting requirements apply to providers of nursing facility services and all home offices who allocate costs to nursing facilities:

- a. Each nursing facility must annually file a cost report with the Division of Medical Assistance which covers a twelve-month period ending June 30th. Cost reports may be e-mailed, mailed or hand-delivered to the Division. If mailed, it must be sent certified mail and be postmarked on or before September 30th. If hand-delivered, it must be received by the Division before the close of business on September 30th. (See Hospital-based facility exception in 2(d) below.)
- b. If such cost reports are not filed by September 30th, the Division shall have the option of either terminating the provider agreement upon thirty days written notice or imposing a penalty of \$50.00 per day for the first thirty days and a penalty of \$100.00 per day for each day thereafter until an acceptable cost report is received by the Division. The only condition in which a penalty will not be imposed is if written approval for an extension is obtained from the Division Director of Nursing Home Reimbursement Services prior to September 30.

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- c. If a cost report is received by the Division prior to September 30th but is unacceptable, it will be returned to the facility for proper completion. No penalty will be imposed if the properly completed report is filed by the September 30th deadline. However, the above described penalties may be imposed after the September 30th deadline until an acceptable cost report is received by the Division.
- d. Hospital-based facilities using Medicare fiscal year ending dates between July and April must submit cost reports to the Division on or before September 30. Facilities using fiscal year ending dates between May and June must submit cost reports on or before November 30. The financial information to be included on the Medicaid cost report must be taken in total from the provider's most recent Medicare cost report that precedes June 30. The rules regarding unacceptability and timeliness described above in sections b. and c. also apply to hospital-based facilities' cost reports.

Approval for extensions beyond the September 30 or November 30 deadline, where applicable, will be granted only if the provider's operations are "significantly adversely affected" because of circumstances beyond the provider's control (i.e., a flood or fire that causes the provider to halt operations). Each provider must submit a written request specifying the hospital-based facility and the reason for the extension.

- e. To be acceptable, a cost report must be complete and accurate, include all applicable schedules, and be correctly internally cross-referenced. Further, the amount per book column for Schedules B and C must agree with the amounts recorded in the facility's general ledger; however, there may have to be certain groupings of the general ledger amounts to agree with the cost report line items. Estimated amounts used for a conversion to a June 30th year-end are not acceptable. Reported costs of interest paid to non-related parties must be reduced by non-related parties must be reduced by an amount equal to the lesser of: (1) interest paid to non-related parties; or (2) investment income other than the exceptions

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identified in CMS-15, Section 202.2. Reported costs of special services must be reduced, as indicated on Schedule B-1A, by an amount resulting from revenue received from sources other than the Division for these services. Adjustments will be based on auditable records of charges to all patients as required by cost report instructions.

- f. All nursing facilities are required to submit to the Division any changes in the amount of or classification of reported costs made on the original cost report within thirty days after the implementation of the original cost report used to set reimbursement rates. Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.
- g. Late cost report penalties will be invoiced through the Accounting Section of the Division for the total amount of the assessed penalty. The provider must submit payment to the Division. Penalties not properly paid will be deducted from the monthly reimbursement check. The assessments will not be refunded.
- h. New facilities which have less than twelve but not less than six months of actual operating cost experience will only submit cost data for their actual months of operation as of June 30. New facilities which have less than six months of actual operating cost experience are not required to submit a cost report. Facilities in which there has been a change of ownership must submit a separate report for each owner. The subsequent owner will be reimbursed based on the previous owner's cost report (with an adjustment in the property cost center only) until a new cost report is received from the new owner and determined reliable and appropriate. The Division will determine whether each submitted cost report is appropriate and reliable as a basis for computing the Allowed Per Diem billing rate and may calculate a facility's Allowed Per Diem billing rate in accordance with Section 1002.3.

For ownership changes effective with at least six months of patient day data on the applicable June 30 fiscal year cost report, the initially